HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

A SEPARATE CLAIM FORM IS REQUIRED FOR EACH FAMILY MEMBER INCURRING EXPENSES

EMPLOYER: _____

EMPLOYEE: _____ PATIENT: _____

RELATIONSHIP TO EMPLOYEE: SELF ☐ SPOUSE ☐ CHILD ☐

PATIENT'S SOC SEC#: _____ PATIENT'S BIRTH DATE: _____

PATIENT IS COVERED BY MEDICARE: YES ☐ NO ☐

MAILING ADDRESS: _____

☐ (check if new address) _____

SERVICE DATE	NAME OF SERVICE PROVIDER	EXPENSES DESCRIPTION*	AMOUNT

*PLEASE ATTACH DETAILED SUPPORTING DOCUMENTATION, SUCH AS ITEMIZED INVOICES OR STATEMENTS.

EMAIL ADDRESS: _____ PLEASE CONFIRM RECEIPT OF CLAIM: ☐

EMPLOYEE SIGNATURE: _____ DATE: _____

My signature certifies that the above medical expenses have not been reimbursed and will not be reimbursed through any other health plan coverage.

To be eligible for reimbursement, claims must be submitted no later than six months after the Plan Year ends.

MAIL OR FAX CLAIMS TO:
BMC BENEFIT SERVICES
790 PENLLYN PIKE, SUITE 217
BLUE BELL, PA 19422
TEL: 215-628-2500
FAX: 215-628-2591